Full Council
Summary of Meeting Minutes
February 19 2018

Introduction and Roll Call
Gerd called the meeting to order and performed the roll call. Full Council attendance is as reflected in the separate roll call sheet. Quorum was not met.

Approval of the Full Council Meeting Minutes of November 7, 2017
Minutes of the Executive Committee meeting of November 7, 2017 was not put to a vote because quorum was not met.

Long-Term Care Ombudsman Report
Cynthia Pederson reviewed the January 2018, Managed Care Ombudsman Monthly Report and the Managed Care Ombudsman Quarterly Report for the last calendar quarter of 2017 available in the materials packet. She stated that the office also provides a quarterly report that reflects a three month compilation of data gathered from the monthly reports. She underscored that the last quarter of 2017 which included the transition period from AmeriHealth Caritas did not result in an increase in the number of contacts received by the Ombudsman program during the quarter. She noted trends involving an increase in contacts regarding selecting or changing an MCO, an increase in contacts regarding continuity of care and services during the transition, and an increase in AmeriHealth members needing assistance in connecting with new case managers. She also noted the decrease in the number of contacts regarding grievances, appeals, and fair hearings.

Recommendations Update
Q4 SFY17 Director Foxhoven Reply
Gerd gave a brief background regarding the questions posed to the Director and a copy of the reply was made available in the materials packet.
Q1 SFY18 Letter
Gerd stated that this letter is currently awaiting response from Director Foxhoven but that the items on the recommendation are already being addressed.

Update from the Medicaid Director
(Electronic Visit Verification (EVV), Legislative Update, Action Items, MCO RFP Development, Status of Choice given only two MCOs)
Mike Randol stated that a vendor(s) had not yet been determined for the EVV initiative nor whether there would be separate vendors for MCOs and Fee-for-Service (FFS). He stated that the EVV is to be implemented by January 1, 2019, and a process timeline is currently being developed to meet that implementation date that covers both education and communication on how to move forward. Mike stated that he did not have a legislative update at that time. In regards to the MCO Requests for Proposals (RFPs), he stated that due dates for RFPs is March 6, 2018, and they will follow standard process of RFP evaluation.. He stated that there may be one or two additional MCOs added to the managed care program with an effective contract date for the selected MCO(s) of July 1, 2019. He stated that as of March 1, 2018, Amerigroup will begin accepting the members who were temporarily transitioned to Fee-for-Service and as of May 1, 2018, they will begin accepting new and choice members. Mike and Liz Matney confirmed that the objective of HSB 632 is to ensure that the data that is being reported is useful data that allow for meaningful analysis. There was a suggestion that the MAAC or a subcommittee of the MAAC hold future discussions with the department to discuss what data elements will be useful for the MAAC especially in light of data reporting changes that will result from HSB 632. Liz added that it is important to understand that data elements will continue to be

collected but that the reports should be able to meaningfully answer questions that are being asked. Mike stated that there is now a process improvement working group and one of the sub-groups is data transparency dashboards which can help in answering questions about the data. Mike also reviewed the action items document and provided an update on the status of each item.

Action Item:

- Add to action items a presentation at a future Executive Committee meeting on value-based purchasing threshold requirements for MCOs.

Long-Term Care Services and Support (LTSS) Presentation

Deb Johnson handed out copies of the document, "Medicaid Home-and Community-Based Services (HCBS) Program Comparison Chart" which outlines the various services under LTSS. She stated that LTSS consists of Home- and Community-Based Services (HCBS) Waivers and Institutional Care:

Home- and Community-Based Services (HCBS) Waivers

Deb stated that HCBS is part of the Social Security Act and is referred to as the 1915c HCBS Waivers. There are seven waivers; Health and Disability; AIDS/HIV, Elderly, Intellectual Disability, Brain Injury, Physical Disability, and Children's Mental Health. HCBS Waivers provide service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. She stated that waiver services are meant to complement or supplement the state plan or other resources that are available. Waiver participants have access to the full state plan but that they still need to meet the institutional Level of Care and services have to be cost-effective or less expensive in aggregate than what it would cost in an institution.

Institutional Care: Nursing Facilities (NFs), Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), and Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs)

Deb stated that members receiving these services need to meet the same Level of Care and income guidelines as in waiver programs. There are monthly maximums or caps on the financial amount for services in each program and this is important in determining the aggregate for cost neutrality. She added that cost-effectiveness of services is determined on an individual basis and is based on a variety of variables. Deb provided clarification on the distinction and relationships between Level of Care, service plan, and care coordination.

Care-Coordination and Conflict-Free Case Management

Amerigroup Iowa, Inc.

Kelly Espeland provided the Centers for Medicare and Medicaid Services (CMS) definition of Conflict-Free Case Management and stated that it is a requirement for the MCOs per their contracts with the State. Additionally, the MCOs must administer case management in a conflict-free manner consistent with the Balancing Incentive Program. The Balancing Incentive Program rebalances the State's program and aims to get more persons into the community and out of facilities. She stated that the MCOs complete member assessments, inform the state of the member's care needs and the State makes the final eligibility determination. In regards to the SIS assessment, the Case Manager (CM) is a facilitator and does not determine the score or the member needs as this is carried out by the team. The information then goes to the CM, the team reviews the information, and the CM provides the service coordination to develop the member's person-centered plan based on identified needs. The Utilization Management (UM) team looks at the assessment and care plan that has been developed, and a determination is then made regarding services in accordance with the Iowa Administrative Code. Conflict-Free Case Management oversight is carried out through regular reports provided to the State and involvement from stakeholder groups such as the MAAC.

UnitedHealthcare Plan of the River Valley, Inc.

Paige Pettit stated that UnitedHealthcare's process is similar to Amerigroup's with slight distinctions. UnitedHealthcare's CMs focus on person-centered planning while ensuring compliance with state and federal regulations. UnitedHealthcare's CMs are nurses as well as social workers and have extensive training in LTSS. Upon hiring, CMs are put through training in LTSS and each CM hired is paired with a mentor. Quality is assured through case reviews, ride-alongs, peer reviews, ongoing education and maintenance of certification is mandatory for all assessors.

Amerigroup Iowa, Inc. Updates

Transition Update

Natalie Kerber stated that when AmeriHealth exited the market, Amerigroup determined that in order to serve a large but unidentified influx of new members, the organization would need to build more

capacity. Since that time, Amerigroup has been working closely with the IME in building said capacity. As of March 1, 2018, Amerigroup will begin accepting the members who were temporarily transitioned to Fee-for-Service and as of May 1, 2018, they will begin accepting new and choice members.

Integrated Health Home Funding
Natalie stated that Amerigroup continues to support the work of the Integrated Health Home (IHH) program and they will continue to work with the Department, UnitedHealthcare, and Health Home providers to identify ways to strengthen the program.

Value-Based Purchasing
Amerigroup's contract benchmarks for members covered by Value-Based provider arrangements are 30% by July 1, 2018, and 40% by the end of 2018. Natalie stated that Amerigroup is on track to meet these goals and they are currently approaching 30% in Value-Based arrangements and fully anticipate meeting their goals. Additionally, Amerigroup has been piloting two quality incentive programs with LTSS providers; Anthem Nursing Facility Quality Incentive Program and Anthem Personal Attendant Care Quality Incentive Program. In these programs, providers are measured on outcomes over an entire year and then there are quarterly reports that are designed to discuss the quality measures with participating providers in order to coach them on improving their performance to meet the pilot goals throughout the year.

UnitedHealthcare Plan of the River Valley Updates

Transition Update
Paige Pettit stated that UnitedHealthcare has hired 525 new employees to accommodate new members and of the 525 new employees, 470 are CMs. Community-Based Case Managers (CBCMs) continue training and member outreach, and all members have been assigned a CBCM. Provider advocates are also traveling across the state to meet with providers on a weekly basis.

Integrated Health Home Funding
The Department is currently conducting a review of the State's health plan program and the associated state plan amendments; the Department will work collaboratively with both MCOs through this process. Given the potential for program changes to occur as a result of the review, the MCOs have delayed the IHH transition. As of March 1, 2018, the IHHs will need to complete for UnitedHealthcare the appropriate documentation to enroll individuals into the IHH that assures compliance with the state plan amendment. As of last week, UnitedHealthcare's clinical staff had conducted joint operating committee meetings with 25 of the IHHs to address their questions.

Quarterly Data Report Update

The Q1 SFY18 report was made available in the materials packet and Liz Matney stated that the report had been updated with information requested from oversight entities and the information had been restructured. She provided data on claims payment accuracy, rate reprocessing, consumer satisfaction survey specific to LTSS members receiving HCBS services, employment services for HCBS Waiver members, HRA completion, claims timeliness, service levels, and Prior Authorizations (PAs).

Secret Shopper Methods and Metrics

Liz stated that someone in the Iowa Medicaid managed care bureau made daily calls to different MCO helplines; provider services, member services, Non-Emergent Medical Transportation (NEMT), and ***hawk-i***. The questions utilized for calls are based on information that the IME is receiving from stakeholder groups, legislators, members, and providers. This information is included in the quarterly report and will be ongoing.

Open Comment (Open Comment Opportunity for Members)

Marsha Fisher stated that her son is an LTSS member. She stated that she has received emails from persons in north eastern Iowa stating that they have gone through repeated appeals to obtain LTSS services, and it seems as though this is what the MCOs expect; this is the process for obtaining LTSS services. Marsha gave an example of a woman whom she knows and who has two small children with severe disabilities receiving LTSS services and her children have been denied services; requiring they go through the appeals process. She stated that the appeals process was frustrating, and requires a lot of effort. Marsha expressed concern if whether this was the process for obtaining LTSS services and stated that it is a problem that the Department needed to be aware of.

Marsha Fisher also stated that she does not agree with the requirement to prove that the services requested are a true need. Marsha noted that the needs are seen by the Care Coordinator, there is an assessment, and there are many persons working with the individual during their care planning

although when it goes to the Utilization Management team, the member and their team are required to prove that the services are a true need; to prove beyond the information that is provided to the Utilization Management team that the services requested are needed.

Marsha Fisher stated that communication continues to be a problem without personalization and individualization. She identified that she had received a satisfaction survey from her son's MCO that had the correct address although was addressed to someone else and the document was in Spanish. She stated that she was concerned about the validity of some of the documents provided to members in the general Medicaid population as well as LTSS members.

Potential Topics for Future Recommendations:

- Percentage of claims that are suspended; suspended versus denied claims. Request that information be provided in future quarterly reports.
- In regards to data within reports, request the addition of measures and information regarding quality. Example: Is the decision made timely and is the decision made correctly?
- Request clearer guidelines of what information is required when requesting services for LTSS members. (See Marsha Fisher's comments outlined above).

Adjourn
4:02 P.M.